

# Female Athlete Issues for the Team Physician: A Consensus Statement

## SUMMARY

*This document provides an overview of select musculoskeletal and medical issues that are important to team physicians who are responsible for the medical care of female athletes. It is not intended as a standard of care, and should not be interpreted as such. This document is only a guide, and as such, is of a general nature, consistent with the reasonable, objective practice of the healthcare professional. Individual treatment will turn on the specific facts and circumstances presented to the physician. Adequate insurance should be in place to help protect the physician, the athlete, and the sponsoring organization.*

*This statement was developed by a collaboration of six major professional associations concerned about clinical sports medicine issues; they have committed to forming an ongoing project-based alliance to bring together sports medicine organizations to best serve active people and athletes. The organizations are: American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.*

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## DEFINITION

*Female athletes experience musculoskeletal injuries and medical problems, resulting from and/or impacting athletic activity. Team physicians must understand the gender-specific implications of these issues.*

## GOAL

*The goal is to assist the team physician in providing optimal medical care for the female athlete.*

## THE FEMALE ATHLETE AND ANTERIOR CRUCIATE LIGAMENT (ACL) INJURIES

### **It is essential the team physician understand:**

- ♦ The female is at increased risk of ACL injury in multiple sports and activities
- ♦ The anatomy, biomechanics and mechanisms of injury of the ACL
- ♦ Treatment strategies including surgical indications

### **It is desirable the team physician:**

- ♦ Understand current prevention strategies
- ♦ Coordinate a network to identify risk factors and implement treatment
- ♦ Understand the potential long-term sequelae of ACL injury

## Epidemiology

- ♦ Non-contact ACL injury rate is two to 10 times higher in female athletes than in their male counterparts.
- ♦ Examples of high-risk sports include basketball, field hockey, lacrosse, skiing and soccer.

## Physiology/Pathophysiology

- ♦ Causes of non-contact ACL injuries may be multi-factorial; proposed risks include environmental, anatomical, hormonal, biomechanical and neuromuscular factors.
- ♦ Non-contact ACL injuries occur commonly during deceleration, landing or cutting. At-risk positions during these maneuvers include knee extension, flat foot, and off-balance body position.

## Evaluation and Treatment

### **It is essential the team physician:**

- ♦ Delineate the mechanism of the injury
- ♦ Conduct a comprehensive physical examination of the knee, including ACL assessment
- ♦ Know the indications for and utility of imaging techniques
- ♦ Know the indications for surgical consideration
- ♦ Facilitate early rehabilitation to improve strength, flexibility and neuromuscular control

### **It is desirable the team physician:**

- ♦ Review the results of imaging studies
- ♦ Understand the principles of the surgical management of the ACL injury

## Prevention

### **It is essential the team physician:**

- ♦ Understand that neuromuscular factors may contribute to increased risk of non-contact ACL injuries, and may be amenable to prevention with specific conditioning programs.

- ◆ Recognize that conditioning programs may need to be gender specific (see “The Team Physician and Conditioning of Athletes for Sports – A Consensus Statement” [2001])

**It is desirable the team physician:**

- ◆ Identify proposed risk factors during the pre-participation evaluation
- ◆ Coordinate a prevention program
- ◆ Educate athletes, parents, coaches and other healthcare providers, including information about at-risk positions and game situations that are associated with ACL injury

## THE FEMALE ATHLETE AND THE PATELLOFEMORAL JOINT

**It is essential the team physician understand:**

- ◆ The anatomy and biomechanics of the patellofemoral joint
- ◆ The mechanisms of patellofemoral pain and dysfunction

**It is desirable the team physician:**

- ◆ Coordinate the evaluation and treatment of athletes with patellofemoral problems
- ◆ Understand the potential long-term sequelae of patellofemoral pain and dysfunction

### Epidemiology

- ◆ Patellofemoral problems occur frequently in female athletes.
- ◆ Patellofemoral pain and dysfunction result from macro-trauma and micro-trauma.

### Physiology/Pathophysiology

- ◆ Normal patellofemoral mechanics involve a balance between bone alignment, articular cartilage, soft tissue (ligaments, muscles, tendons, fascia) and coordinated neuromuscular activation.
- ◆ Patellofemoral pain and dysfunction are multi-factorial, including malalignment, articular cartilage lesions, instability, soft tissue factors and psychosocial issues.
- ◆ Patellofemoral pain may occur in what appears to be a normal knee joint.
- ◆ Risk factors include:
  - Static and/or dynamic malalignment of the pelvis, hip, knee, ankle and foot
  - Muscle weakness and/or imbalance and inflexibility
  - Altered patellar position and/or morphology
  - Trauma, overuse and/or training errors

### Evaluation and Treatment

**It is essential the team physician:**

- ◆ Delineate key points relating to the history of the patellofemoral problem
- ◆ Conduct a specific examination for the patellofemoral problem
- ◆ Know the indications for and utility of imaging techniques

- ◆ Understand non-operative management of patellofemoral problems, including patient education, activity modification, rehabilitation, bracing, orthoses and medications

**It is desirable the team physician:**

- ◆ Review the results of imaging studies
- ◆ Understand the principles of and indications for surgical management

## Prevention

**It is essential the team physician:**

- ◆ Know the risk factors for patellofemoral problems

**It is desirable the team physician:**

- ◆ Identify risk factors during the pre-participation evaluation
- ◆ Implement a screening program for risk factors
- ◆ Educate athletes, parents, coaches, administrators and health-care providers

## THE FEMALE ATHLETE AND SHOULDER CONDITIONS

**It is essential the team physician understand:**

- ◆ The anatomy and biomechanics of the shoulder
- ◆ The mechanisms of shoulder injury and dysfunction

**It is desirable the team physician:**

- ◆ Recognize that shoulder conditions may result from strength and flexibility imbalances or injuries elsewhere in the body
- ◆ Identify risk factors associated with shoulder conditions
- ◆ Coordinate the evaluation and treatment of shoulder conditions

### Epidemiology

- ◆ Examples of high-risk sports include diving, gymnastics, swimming, tennis, throwing sports and volleyball.
- ◆ Shoulder conditions result from macro-trauma and micro-trauma.

### Physiology/Pathophysiology

- ◆ The integration of coordinated neuromuscular activation, capsular/ligament stiffness, and glenohumeral and scapulothoracic positioning is key to shoulder function.
- ◆ The female athlete’s shoulder is at-risk for injury due to increased biomechanical load, resulting from specific risk factors, including:
  - Increased joint laxity (translation)
  - Increased muscle and joint flexibility (range of motion)
  - Decreased upper-body strength and poor posture
  - Acquired internal rotation deficits

### Evaluation and Treatment

**It is essential the team physician:**

- ◆ Delineate key points relating to the history of the shoulder condition

- ◆ Conduct a comprehensive examination for the shoulder condition, including assessment of range of motion, instability, rotator cuff pathology, and scapular dysfunction
- ◆ Know the indications and utility of imaging techniques
- ◆ Understand the principles of shoulder rehabilitation

**It is desirable the team physician:**

- ◆ Evaluate strength and flexibility imbalances or injuries elsewhere in the body which may contribute to shoulder conditions
- ◆ Review the results of imaging studies
- ◆ Understand the principles of and indications for surgical management

**Prevention**

**It is essential the team physician:**

- ◆ Know the risk factors for shoulder conditions

**It is desirable the team physician:**

- ◆ Identify risk factors during the pre-participation evaluation
- ◆ Implement a screening program for risk factors
- ◆ Educate athletes, parents, coaches, administrators and health-care providers

**THE FEMALE ATHLETE AND STRESS FRACTURES**

**It is essential the team physician understand:**

- ◆ A stress fracture in a female athlete can be an isolated injury, or may indicate underlying medical and psychosocial problems. Therefore, evaluation and treatment must take into account the etiology of the stress fracture.
- ◆ Certain stress fractures are at high-risk for complications and long-term sequelae.

**It is desirable the team physician:**

- ◆ Coordinate, when necessary, multi-disciplinary evaluation and treatment

**Epidemiology**

- ◆ Stress fractures occur frequently in female athletes.
- ◆ Some studies suggest a higher incidence of stress fractures in females, but there is little evidence to support a gender difference in stress fractures among trained athletes.
- ◆ Common anatomical areas include the foot, tibia, fibula, femur and pelvis.

**Physiology/Pathophysiology**

- ◆ Stress fractures occur when bone is subjected to repetitive loads beyond its physiologic capacity.
- ◆ An imbalance between bone resorption and deposition creates bone that may not withstand repetitive loads.
- ◆ Risk factors associated with stress fractures include:
  - Extrinsic factors (exercise [type, volume and intensity], footwear)
  - Intrinsic musculoskeletal factors (muscle strength and balance, limb alignment)

- Medical factors (osteopenia, osteoporosis, menstrual dysfunction, poor nutrition, disordered eating and other psychosocial issues)

**Evaluation and Treatment**

**It is essential the team physician:**

- ◆ Delineate key points relating to the history of the stress fracture
- ◆ Conduct a specific physical examination pertinent to the suspected stress fracture
- ◆ Identify potential underlying risk factors
- ◆ Know the indications for and utility of imaging techniques
- ◆ Identify stress fractures at high-risk of complication and long-term sequelae
- ◆ Know the indications for surgical consideration
- ◆ Understand non-operative management and rehabilitation

**It is desirable the team physician:**

- ◆ Review the results of the imaging studies
- ◆ Understand the principles of and indications for surgical management
- ◆ Coordinate, when necessary, a multi-disciplinary team approach to treatment

**Prevention**

**It is essential the team physician:**

- ◆ Recognize there can be multiple risk factors for stress fractures

**It is desirable the team physician:**

- ◆ Recognize risk factors during the pre-participation evaluation
- ◆ Implement a screening program for risk factors
- ◆ Educate athletes, parents, coaches, administrators and health-care providers

**THE FEMALE ATHLETE AND OSTEOPENIA AND OSTEOPOROSIS**

**It is essential the team physician understand:**

- ◆ Osteopenia and osteoporosis can exist in the young female athlete
- ◆ These conditions have implications for athletic performance and long-term sequelae
- ◆ Disordered eating and menstrual dysfunction are common risk factors

**It is desirable the team physician understand:**

- ◆ The evaluation and treatment of osteopenia and osteoporosis
- ◆ The importance of educating athletes, parents, coaches, administrators and healthcare providers
- ◆ The value of prevention and early detection of osteopenia and osteoporosis

**Epidemiology**

- ◆ The incidence of osteopenia and osteoporosis in the female athlete is unknown.

- ◆ Several studies have demonstrated osteopenia and osteoporosis in young female athletes with menstrual dysfunction and/or eating disorders.
- ◆ The major determinant of adult bone mineral density (BMD) is bone mass achieved during adolescence and young adulthood. Osteoporosis-related fractures in later life are associated with significant morbidity and mortality.

## Physiology/Pathophysiology

- ◆ Bone mass depends on the overall balance between resorption and deposition.
- ◆ Ninety percent of total bone mineral content is accrued by the end of adolescence, creating a window of opportunity to maximize BMD.
- ◆ Eighty percent of variance in BMD is attributed to genetic factors. Lean body mass, estrogen, exercise, and calcium intake are other important influences.
- ◆ Tobacco use, excessive alcohol consumption, certain medical conditions (e.g., renal disease, hyperparathyroidism), and medications (e.g., glucocorticoids) can negatively affect bone density.
- ◆ Athletes involved in impact sports and/or strength training routinely have higher site-specific BMD than athletes in non-impact sports and non-athletes.
- ◆ The effect of impact activities and/or strength training is most pronounced during puberty and dependent upon intensity and volume of conditioning (see “The Team Physician and Conditioning of Athletes for Sports – A Consensus Statement” [2001]).

## Evaluation and Treatment

### It is essential the team physician:

- ◆ Recognize risk factors for low bone mineral density
- ◆ Know the indications for and the utility of imaging techniques
- ◆ Facilitate treatment for osteopenia and osteoporosis once identified

### It is desirable the team physician:

- ◆ Understand criteria for osteopenia (one to 2.5 standard deviations [SD] below young adult mean BMD) and osteoporosis (greater than 2.5 SD below young adult mean BMD).
- ◆ Coordinate a screening process to identify athletes at-risk
- ◆ Coordinate a comprehensive evaluation including assessment of menstrual status and nutritional intake, measurement of BMD and laboratory testing as necessary
- ◆ Understand that multi-disciplinary treatment may include restoration of normal menstrual cycles, optimization of physical activity and nutrition, psychological therapy, and pharmacological intervention.

## Prevention

### It is essential the team physician understand:

- ◆ Optimal BMD is achieved by maintaining physiologic estrogen levels, adequate nutrition, and load-bearing exercise
- ◆ The importance of prevention and early detection of osteopenia and osteoporosis

### It is desirable the team physician:

- ◆ Identify risk factors during the pre-participation evaluation
- ◆ Implement a screening program for risk factors, including information regarding strategies for maintaining optimal BMD and the effect of negative behaviors on BMD
- ◆ Educate athletes, parents, coaches, administrators and health-care professionals

## THE FEMALE ATHLETE AND DISORDERED EATING

### It is essential the team physician understand:

- ◆ The importance of adequate nutrition in sports
- ◆ The spectrum of disordered eating and how it affects the female athlete
- ◆ Disordered eating can occur in any sport

### It is desirable the team physician understand:

- ◆ The evaluation and treatment of the athlete with disordered eating
- ◆ The importance of educating athletes, coaches, parents, administrators and other healthcare providers
- ◆ The value of prevention and early detection of disordered eating

## Epidemiology

- ◆ Disordered eating occurs on a spectrum. This ranges from calorie, protein and/or fat restriction and pathogenic weight control measures (e.g., diet pills, laxatives, excessive exercise, self-induced vomiting) to classic Eating Disorders, such as Anorexia Nervosa and Bulimia Nervosa.
- ◆ Athletes in sports involving aesthetics, endurance and weight classifications are at particular risk for the spectrum of disordered eating.
- ◆ Fifteen to 62 percent of college female athletes report a history of disordered eating.
- ◆ Eating Disorders are psychiatric disorders with distortion of body image, significant nutritional and medical complications, including a mortality rate of 12 to 18 percent for untreated AN.
- ◆ Female athletes are at higher risk for developing Eating Disorders than the general population.

## Physiology/Pathophysiology

- ◆ Nutritional and medical consequences of the spectrum of disordered eating include:
  - Nutritional deficiencies and electrolyte disturbances
  - Decreased bone mineral density (BMD)
  - Gastrointestinal problems (e.g., bleeding, ulceration, bloating, constipation)
  - Cardiovascular abnormalities (e.g., arrhythmias, heart block)
  - Psychiatric problems (e.g., depression, anxiety, suicide)
- ◆ Risk factors include:
  - Pressure to optimize performance and/or modify appearance

- o Psychological factors, such as low self esteem, poor coping skills, perceived loss of control, perfectionism, obsessive compulsive traits, depression, anxiety and history of sexual/physical abuse
- o Underlying chronic diseases related to caloric utilization (e.g., diabetes)

## Evaluation and Treatment

### It is essential the team physician:

- ◆ Recognize risk factors for the spectrum of disordered eating
- ◆ Facilitate treatment once identified with a multi-disciplinary approach as needed
- ◆ Understand the necessity of mental health treatment for Eating Disorders

### It is desirable the team physician:

- ◆ Coordinate a screening process to identify athletes at-risk
- ◆ Understand a comprehensive evaluation includes assessment of nutrition, exercise behaviors, pathogenic weight control measures and psychosocial factors; additional laboratory and other diagnostic testing as necessary.
- ◆ Understand treatment may involve a multi-disciplinary approach (medical, mental health, and nutritional management), including parents, coaches, Certified Athletic Trainers, physical therapists, and administrators.

## Prevention

### It is essential the team physician understand:

- ◆ The importance of prevention and early detection of the spectrum of disordered eating

### It is desirable the team physician:

- ◆ Identify risk factors during the pre-participation evaluation
- ◆ Implement a screening program for risk factors, including information to dispel misconceptions about body weight, body composition and athletic performance
- ◆ Educate athletes, parents, coaches, administrators and health-care providers

## THE FEMALE ATHLETE AND SELECTED MENSTRUAL DYSFUNCTION

### It is essential the team physician understand:

- ◆ The normal menstrual cycle and the spectrum of menstrual dysfunction
- ◆ The consequences of menstrual dysfunction on bone density and fertility

### It is desirable the team physician understand:

- ◆ The evaluation and treatment of the athlete with menstrual dysfunction
- ◆ The importance of educating athletes, parents, coaches, administrators and healthcare providers about menstrual dysfunction
- ◆ The value of prevention and early detection of menstrual dysfunction

## Epidemiology

- ◆ Menstrual dysfunction occurs in different forms:
  - o Delayed menarche (onset of menstrual cycles after 16 years of age)
  - o Secondary amenorrhea (absence of menses for three or more months after regular menses has been established)
  - o Oligomenorrhea (six to nine cycles per year; cycle length greater than 35 days or less than three months)
  - o Anovulation (absence of ovulation; may have regular menstrual bleeding)
  - o Luteal phase deficiency (cycle length may be normal, but there are decreased progesterone levels)
- ◆ In the athlete, menstrual dysfunction is at least two to three times more common than in the non-athlete; 10 to 15 percent have amenorrhea or oligomenorrhea.

## Physiology/Pathophysiology

- ◆ Normal menstrual cycle depends on intact hypothalamic-pituitary-ovarian (HPO) axis and normal pelvic organ function.
- ◆ The etiology of menstrual dysfunction is multi-factorial, including body weight and body composition, nutrition, training, previous menstrual function and psychosocial factors.
- ◆ The energy drain hypothesis states that energy expenditure exceeds stored and consumed energy, leading to disruption of the HPO axis.
- ◆ Intense exercise alone does not necessarily cause menstrual dysfunction, provided there is adequate caloric intake for the energy needs.
- ◆ Consequences of menstrual dysfunction may include lower levels of estrogen and/or progesterone, lower bone mineral density (BMD), higher incidence of stress fractures and infertility.
- ◆ Effects of lower levels of estrogen on BMD are not completely reversible, therefore early detection and treatment of menstrual dysfunction is important.

## Evaluation and Treatment

### It is essential the team physician:

- ◆ Understand menstrual dysfunction related solely to exercise is a diagnosis of exclusion
- ◆ Recognize risk factors for and implications of menstrual dysfunction
- ◆ Facilitate treatment of these conditions once identified, with a multi-disciplinary approach as necessary

### It is desirable the team physician:

- ◆ Coordinate a screening program to identify athletes at risk
- ◆ Understand that a comprehensive evaluation includes assessment for other causes of menstrual dysfunction, detailed menstrual, nutrition and medication history; laboratory testing and additional diagnostic testing as necessary.
- ◆ Understand that treatment may include increasing caloric intake, decreasing energy expenditure, hormone supplementation and psychotherapy as necessary

## Prevention

### It is essential the team physician understand:

- ♦ The importance of prevention and early detection of menstrual dysfunction

### It is desirable the team physician:

- ♦ Identify risk factors during the pre-participation evaluation
- ♦ Implement a screening program for risk factors, including information about the importance of normal menstrual function
- ♦ Educate athletes, parents, coaches, administrators and health-care providers

## THE FEMALE ATHLETE AND PREGNANCY/CONTRACEPTION

*The majority of team physicians do not provide obstetrical care for female athletes, nor do they offer specific contraceptive counseling. Prenatal and post partum care in the United States is generally carried out by an obstetrician/ gynecologist and/or family medicine physician. Team physicians may defer to the specific expertise of the physician(s) providing primary obstetric care, but can coordinate and collaborate in the management of sports-related injuries and illnesses.*

### It is essential the team physician:

- ♦ Recognize the signs and symptoms of pregnancy
- ♦ Understand that absolute and relative contraindications to exercise throughout pregnancy exist
- ♦ Understand the importance of family planning and contraception

### It is desirable the team physician understand:

- ♦ Basic physiologic changes associated with pregnancy and the postpartum period
- ♦ Sport-specific risks and benefits of exercise in pregnancy and exercise prescription
- ♦ The effects of certain medications on maternal and fetal health
- ♦ Medical and obstetrical conditions affecting participation and performance
- ♦ Specific considerations in the pregnant athlete, including nutritional needs, environmental risks, appropriate use of imaging, and contraindications for physical therapy modalities
- ♦ Contraceptive methods and alternatives, at-risk behaviors for unplanned pregnancy, as well as sexually transmitted diseases (STDs)

## Epidemiology

- ♦ Exercise throughout pregnancy is generally safe, but must be carefully monitored and limitations applied as necessary.
- ♦ Benefits of exercise throughout pregnancy include:
  - o Avoidance of excessive weight gain, improved balance and decreased back pain
  - o Improved well-being, energy levels and sleep patterns
  - o Improved labor symptoms and facilitation of post-partum recovery

- ♦ Risks include environmental exposure, dehydration, hypoxia and uterine trauma
- ♦ Contraceptive methods have different efficacies, potential side effects and risks for STDs.
  - o In certain populations, there may be a positive association between oral contraceptive use and bone mineral density (BMD).
  - o Use of injectable depot medroxyprogesterone acetate may lead to amenorrhea, lower estrogen levels and decreased BMD.
- ♦ Unplanned pregnancy and/or presence of STDs indicates high-risk behavior

## Physiology/Pathophysiology

- ♦ Physiological changes that may affect exercise throughout pregnancy include:
  - o Musculoskeletal changes including weight gain
  - o Medical changes including increased heart rate, cardiac output, blood volume, and respiratory rate
- ♦ The goals of exercise throughout pregnancy are to maintain or improve pre-existing levels of maternal fitness without undue risk to the mother or the developing fetus.
- ♦ Pregnancy increases nutritional needs for calories, iron, calcium and folic acid
- ♦ Exercise in the supine position after 16 weeks should be avoided due to potential great vessel compression

## Evaluation and Treatment

### It is essential the team physician understand:

- ♦ There are specific issues of the female athlete in terms of pregnancy and contraception

### It is desirable the team physician:

- ♦ Facilitate obstetric care and treatment, including referral
- ♦ Understand evaluation includes a medical examination, nutritional assessment and ongoing assessment of absolute and relative contraindications to exercise throughout pregnancy and the postpartum period.
- ♦ Understand treatment may include the limitation of physical activity as pregnancy progresses and that discussion with others (i.e. healthcare providers, parents, coaches, and Certified Athletic Trainers) may be necessary.

## Prevention

### It is essential the team physician understand:

- ♦ The importance of family planning and contraceptive options for the athlete
- ♦ The implications of pregnancy and postpartum for training and competition

### It is desirable the team physician:

- ♦ Implement a screening and education program for athletes at-risk for pregnancy, including information regarding safe sexual practices, family planning and contraceptive options.
- ♦ Educate athletes, parents, coaches, administrators and health-care providers as to the benefits and risks of exercise throughout pregnancy and the postpartum period.

## AVAILABLE RESOURCES

Ongoing education pertinent to the team physician is essential. Information regarding team physician-specific educational opportunities can be obtained from the six participating organizations:

American Academy of Family Physicians (AAFP)  
11400 Tomahawk Creek Pkwy  
Leawood, KS 66211  
800-274-2237  
www.aafp.org

American Academy of Orthopaedic Surgeons (AAOS)  
6300 N River Rd  
Rosemont, IL 60018  
800-346-AAOS  
www.aaos.org

American College of Sports Medicine (ACSM)  
401 W Michigan St  
Indianapolis, IN 46202  
317-637-9200  
www.acsm.org

American Medical Society for Sports Medicine (AMSSM)  
11639 Earnshaw  
Overland Park, KS 66210  
913-327-1415  
www.amssm.org

American Orthopaedic Society for Sports Medicine (AOSSM)  
6300 N River Rd, Suite 500  
Rosemont, IL 60018  
847-292-4900  
www.sportsmed.org

American Osteopathic Academy of Sports Medicine (AOASM)  
7611 Elmwood Ave, Suite 201  
Middleton, WI 53562  
608-831-4400  
www.aoasm.org

## SELECTED READINGS

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